

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0028522</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>The Carle Arbours</u>		<b>I have examined the contents of the accompanying report to the</b> <b>State of Illinois, for the period from</b> <u>07/01/01</u> <b>to</b> <u>06/30/02</u> <b>and certify to the best of my knowledge and belief that the said contents</b> <b>are true, accurate and complete statements in accordance with</b> <b>applicable instructions. Declaration of preparer (other than provider)</b> <b>is based on all information of which preparer has any knowledge.</b>	
<b>Address:</b> <u>302 Burwash</u> <u>Savoy</u> <u>61874</u> <div style="display: flex; justify-content: space-between;"> <span>Number</span> <span>City</span> <span>Zip Code</span> </div>		<b>Intentional misrepresentation or falsification of any information</b> <b>in this cost report may be punishable by fine and/or imprisonment.</b>	
<b>County:</b> <u>Champaign</u>		<b>Officer or Administrator of Provider</b>	
<b>Telephone Number:</b> <u>(217) 383-3090</u> <b>Fax # ( 217 ) 383-3194</b>		(Signed) _____ (Date) _____	
<b>IDPA ID Number:</b> <u>371155535001</u>		(Type or Print Name) <u>JAMES SNIDER</u>	
<b>Date of Initial License for Current Owners:</b> <u>02/01/84</u>		(Title) <u>ADMINISTRATOR</u>	
<b>Type of Ownership:</b>		(Signed) _____ (Date) _____	
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>		<b>Paid Preparer</b>	
<input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust		(Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )	
<b>IRS Exemption Code</b> _____		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630	
<b>PROPRIETARY</b>			
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
<b>GOVERNMENTAL</b>			
<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>James A. Cagle</u> <b>Telephone Number:</b> <u>(217) 383-4718</u>			

## STATE OF ILLINOIS

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Facility Name & ID Number The Carle Arbours# 0028522 Report Period Beginning: 07/01/01 Ending: 06/30/02

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>240</u>	Skilled (SNF)	<u>240</u>	<u>87,600</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>240</u>	TOTALS	<u>240</u>	<u>87,600</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,328</u>	<u>1,678</u>	<u>6,999</u>	<u>13,005</u>	8
9	SNF/PED					9
10	ICF	<u>23,716</u>	<u>21,248</u>		<u>44,964</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,044</u>	<u>22,926</u>	<u>6,999</u>	<u>57,969</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 66.17%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 02/01/84

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 02/01/84 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 43 and days of care provided 6,999Medicare Intermediary MUTUAL OF OMAHA

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/02 Fiscal Year: 06/30/02

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

The Carle Arbours

# 0028522

Report Period Beginning:

07/01/01

Ending:

06/30/02

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	398,354	32,059	148	430,561		430,561	(2,057)	428,504		1
2	Food Purchase		323,749		323,749		323,749	(349)	323,400		2
3	Housekeeping	151,744	15,175	1,246	168,165		168,165		168,165		3
4	Laundry	71,592	13,058	9,184	93,834		93,834		93,834		4
5	Heat and Other Utilities			160,827	160,827	(2,518)	158,309		158,309		5
6	Maintenance	47,220	30,295	105,168	182,683	(62,273)	120,410	503	120,913		6
7	Other (specify):*					63,782	63,782		63,782		7
8	<b>TOTAL General Services</b>	668,910	414,336	276,573	1,359,819	(1,009)	1,358,810	(1,903)	1,356,907		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	2,081,089	301,516	501,456	2,884,061	35,711	2,919,772	(449)	2,919,323		10
10a	Therapy	45,033	5,044	611,355	661,432		661,432		661,432		10a
11	Activities	102,982	5,672	3,231	111,885	50	111,935	(11,055)	100,880		11
12	Social Services	104,717			104,717		104,717		104,717		12
13	Nurse Aide Training					14,646	14,646	14,777	29,423		13
14	Program Transportation			78	78	501	579		579		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,333,821	312,232	1,125,720	3,771,773	50,908	3,822,681	3,273	3,825,954		16
	<b>C. General Administration</b>										
17	Administrative			280,542	280,542	74,000	354,542	710,859	1,065,401		17
18	Directors Fees										18
19	Professional Services			207,103	207,103		207,103	(134,616)	72,487		19
20	Dues, Fees, Subscriptions & Promotions			51,827	51,827	2,194	54,021	(23,844)	30,177		20
21	Clerical & General Office Expenses	166,233	21,705	172,094	360,032	(118,823)	241,209	(7,902)	233,307		21
22	Employee Benefits & Payroll Taxes			725,524	725,524		725,524		725,524		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,005	6,005	(1,614)	4,391	(1,949)	2,442		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			82,581	82,581		82,581		82,581		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	166,233	21,705	1,525,676	1,713,614	(44,243)	1,669,371	542,548	2,211,919		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,168,964	748,273	2,927,969	6,845,206	5,656	6,850,862	543,918	7,394,780		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number      The Carle Arbours

#0028522

Report Period Beginning:

07/01/01

Ending:

06/30/02

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			314,673	314,673		314,673	(5,566)	309,107			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			432,000	432,000		432,000	(1,267)	430,733			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,779	7,779	(588)	7,191		7,191			35
36	Other (specify):* Shared A & G Hosp Capital, loss/gain on disp,interest							94,967	94,967			36
37	<b>TOTAL Ownership</b>			754,452	754,452	(588)	753,864	88,134	841,998			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		771,997		771,997		771,997	445,198	1,217,195			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,468	136,468	(5,068)	131,400		131,400			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		771,997	136,468	908,465	(5,068)	903,397	445,198	1,348,595			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,168,964	1,520,270	3,818,889	8,508,123		8,508,123	1,077,250	9,585,373			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number The Carle Arbours

# 0028522

Report Period Beginning:

07/01/01

Ending:

06/30/02

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,057)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(42)	21		10
11	Discounts, Allowances, Rebates & Refunds	(291)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(5,566)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(46)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,902)	21		24
25	Fund Raising, Advertising and Promotional	(23,844)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(15,392)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (72,140)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	1,149,390		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,149,390		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ 1,077,250		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

The Carle Arbours

ID# 0028522

Report Period Beginning: 07/01/01

Ending: 06/30/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	INVESTMENT INCOME	\$ (1,267)	32	1
2	UNALLOWABLE P/R & ENT	(1,220)	11	2
3	UNALLOWABLE ADVERTISING	(113)	21	3
4	NON-DIRECT CARE TRAVEL	(1,949)	24	4
5	ACTIVITY INCOME	(9,835)	11	5
6	FOOD SERVICE REBATE	(349)	2	6
7	UNALLOWABLE NURSING	(158)	10	7
8	UNALLOWABLE PURCHASED SVCS	(501)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(15,392)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number The Carle Arbours

# 0028522

Report Period Beginning:

07/01/01

Ending:

06/30/02

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(2,057)	0	0	0	0	0	0	0	0	0	0	(2,057)	1
2	Food Purchase	(349)	0	0	0	0	0	0	0	0	0	0	(349)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	503	0	0	0	0	0	0	0	0	0	503	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,406)</b>	<b>503</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,903)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(449)	0	0	0	0	0	0	0	0	0	0	(449)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(11,055)	0	0	0	0	0	0	0	0	0	0	(11,055)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	14,777	0	0	0	0	0	0	0	0	0	14,777	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(11,504)</b>	<b>14,777</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,273</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	710,859	0	0	0	0	0	0	0	0	0	710,859	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(134,616)	0	0	0	0	0	0	0	0	0	(134,616)	19
20	Fees, Subscriptions & Promotions	(23,844)	0	0	0	0	0	0	0	0	0	0	(23,844)	20
21	Clerical & General Office Expenses	(25,604)	17,702	0	0	0	0	0	0	0	0	0	(7,902)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,949)	0	0	0	0	0	0	0	0	0	0	(1,949)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(51,397)</b>	<b>593,945</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>542,548</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(65,307)</b>	<b>609,225</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>543,918</b>	<b>29</b>



Facility Name & ID Number    The Carle Arbours#    0028522

Report Period Beginning:

07/01/01

Ending:

06/30/02

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>The Carle Foundation</u>	<u>100</u>			<u>Carle Hospital</u>	<u>Urbana</u>	<u>Hospital/DME/Rx</u>
				<u>Carle HealthCare</u>	<u>Urbana</u>	<u>Ambulance</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.    ☒ YES    ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	<u>Home Office-Misc. Gen. Svcs.</u>	\$	<u>Carle Foundation</u>	<u>100.00%</u>	\$ <u>503</u>	\$ <u>503</u>	1
2	V	17	<u>Home Office-Administrative</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>93,519</u>	<u>93,519</u>	2
3	V	17	<u>Shared A&amp;G Hosp Gen. Svcs.</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>617,340</u>	<u>617,340</u>	3
4	V	19	<u>Home Office-Other Prof. Fees</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>52,518</u>	<u>52,518</u>	4
5	V	21	<u>Home Office-Purch. Svcs.</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>16,488</u>	<u>16,488</u>	5
6	V	21	<u>Home Office-Operating Supp.</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>1,214</u>	<u>1,214</u>	6
7	V	36	<u>Home Office - Loss/gain on Disp</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>40,440</u>	<u>40,440</u>	7
8	V	36	<u>Shared A &amp; G Hosp Capital</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>31,456</u>	<u>31,456</u>	8
9	V	13	<u>Mgmt. Fee-CNA Training</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>14,777</u>	<u>14,777</u>	9
10	V	19	<u>Management Fees</u>	<u>187,134</u>	<u>Carle Foundation</u>	<u>100.00%</u>		<u>(187,134)</u>	10
11	V	10a	<u>PT, OT &amp; ST</u>	<u>611,355</u>	<u>Carle Foundation</u>	<u>100.00%</u>	<u>611,355</u>		11
12	V	39	<u>Pharmacy &amp; Drugs</u>	<u>718,062</u>	<u>Carle Foundation</u>	<u>100.00%</u>	<u>1,163,260</u>	<u>445,198</u>	12
13	V	36	<u>Home Office -Interest Expense</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>23,071</u>	<u>23,071</u>	13
14	Total			\$ <u>1,516,551</u>			\$ <u>2,665,941</u>	\$ * <u>1,149,390</u>	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/01 Ending: 06/30/02

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/01 Ending: 06/30/02

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization The Carle Foundation  
 Street Address 611 W. Park St.  
 City / State / Zip Code Urbana, IL 61801  
 Phone Number ( 217-383-4718  
 Fax Number ( 217-383-4588

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Home Office-Misc. Gen. Svcs.	Direct Costs	12	\$ 503	\$	12	\$ 503	1
2	17	Home Office-Administrative	Direct Costs	12	93,519	67,702	12	93,519	2
3	19	Home Office-Other Prof. Fees	Direct Costs	12	52,518		12	52,518	3
4	21	Home Office-Purch Svcs.	Direct Costs	12	16,488		12	16,488	4
5	21	Home Office-Operating Supp	Direct Costs	12	1,214		12	1,214	5
6	36	Home Office - Loss/gain on Disp	Direct Costs	12	40,440		12	40,440	6
7	17	Shared A & G Hosp. Gen. Svcs.	Direct Costs	12	617,340	225,986	12	617,340	7
8	36	Shared A & G Hosp. Capital	Direct Costs	12	31,456		12	31,456	8
9	36	Home Office - Interest Exp	Direct Costs	12	23,071		12	23,071	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 876,549	\$ 293,688		\$ 876,549	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	\$26.00 Million Bond Issue	x		Refinance/Remodel	N/A	06/01/96	\$ 1,086,927	\$ 984,035	Multiple	Variable	\$ 61,580	1							
2	\$49.99 Million Bond Issue	x		Refinance/Remodel	N/A	05/01/98	4,721,506	4,434,996	Multiple	Variable	196,744	2							
3	\$29.30 Million Bond Issue	x		Refinance/Remodel	N/A	07/01/99	253,671	240,684	Multiple	Variable	4,444	3							
4	\$70.00 Million Bond Issue	x		Refinance/Remodel	N/A	10/27/99			Multiple	Variable		4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 6,062,104	\$ 5,659,715				\$ 262,768	9						
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$				\$	14						
15	TOTALS (line 9+line14)						\$ 6,062,104	\$ 5,659,715				\$ 262,768	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **The Carle Arbours**# **0028522** Report Period Beginning: **07/01/01** Ending: **06/30/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2001 report.		\$	1										
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2										
3. Under or (over) accrual (line 2 minus line 1).		\$	3										
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4										
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5										
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7										
Real Estate Tax History:													
Real Estate Tax Bill for Calendar Year:	1997 <u>          </u> 8 1998 <u>          </u> 9 1999 <u>          </u> 10 2000 <u>          </u> 11 2001 <u>          </u> 12	<table border="1"> <tr> <td colspan="2"><b>FOR OHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2001 \$ 13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ 14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$ 15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ 16</td> </tr> </table>		<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13	14	PLUS APPEAL COST FROM LINE 5 \$ 14	15	LESS REFUND FROM LINE 6 \$ 15	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<b>FOR OHF USE ONLY</b>													
13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13												
14	PLUS APPEAL COST FROM LINE 5 \$ 14												
15	LESS REFUND FROM LINE 6 \$ 15												
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16												

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	The Carle Arbours	COUNTY	Champaign
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CONTACT PERSON REGARDING THIS REPORT

#### A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u>
Index Number	Property Description	Total Tax	Nursing Home

## B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 62,028

B. General Construction Type:
 Exterior
 BRICK
 Frame
 WOOD
 Number of Stories
 2

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	174,240	1984	\$ 274,934	1
2					2
3	TOTALS	174,240		\$ 274,934	3

Facility Name &amp; ID Number The Carle Arbours

# 0028522

Report Period Beginning:

07/01/01

Ending:

06/30/02

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	240		1984	1973	\$ 2,967,466	\$ 84,785	35	\$ 84,785		\$ 1,561,453	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	RENOVATIONS		1984		267,128	9,152	VARIOUS	9,152		203,133	9
10	WINDOWS		1984		6,326		VARIOUS			6,326	10
11	SIGNS & A/C		1984		25,006		VARIOUS			25,006	11
12	LANDSCAPING		1985		13,589	371	VARIOUS	371		13,219	12
13	PLUMBING		1985		34,747	1,390	VARIOUS	1,390		23,952	13
14	ROOF & ELECTRICAL		1985		23,658	680	VARIOUS	680		21,398	14
15	KITCHEN REMODEL		1985		24,371	693	VARIOUS	693		19,218	15
16	LANDSCAPING		1986		7,325		VARIOUS			7,325	16
17	RENOVATIONS		1986		31,097	786	VARIOUS	786		24,219	17
18	LANDSCAPING		1987		2,032	135	VARIOUS	135		2,021	18
19	ROOF REPAIR		1987		749	50	VARIOUS	50		749	19
20	CARPET		1987		6,689	372	VARIOUS	372		6,689	20
21	RENOVATIONS		1987		28,041	1,562	VARIOUS	1,562		28,031	21
22	CARPET & FLOORING		1988		21,483	1,432	VARIOUS	1,432		20,528	22
23	ALZHEIMERS ADDITION		1988		1,400	47	VARIOUS	47		657	23
24	GENERATOR		1988		11,693	275	VARIOUS	275		10,020	24
25	INSULATION		1988		3,650	183	VARIOUS	183		2,570	25
26	RENOVATIONS		1988		6,774	87	VARIOUS	87		6,571	26
27	ALZHEIMERS/2ND FLOOR RENOVATION		1990		6,214	301	VARIOUS	301		3,910	27
28	EMERGENCY POWER DISTRIBUTION		1990		27,115	1,334	VARIOUS	1,334		16,128	28
29	DOORS		1990		1,388	93	VARIOUS	93		1,141	29
30	REMODELING		1990		2,838	142	VARIOUS	142		1,655	30
31	REMODELING		1991		472,549	20,391	VARIOUS	20,391		226,547	31
32	FLOORING		1991		87,008	3,749	VARIOUS	3,749		63,021	32
33	RENOVATIONS		1991		1,981	57	VARIOUS	57		1,523	33
34	RENOVATIONS		1992		5,150	343	VARIOUS	343		3,419	34
35	ROOF REPAIR		1992		22,257	1,113	VARIOUS	1,113		22,257	35
36	FLOORING		1992		14,427	702	VARIOUS	702		10,682	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12B, Line 104 for Grand Totals

## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number    The Carle Arbours

#    0028522

Report Period Beginning:

07/01/01

Ending:

06/30/02

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	LANDSCAPING	1992	\$ 4,734	\$ 473	VARIOUS	\$ 473	\$	\$ 4,616	37	
38	OUTDOOR LIGHTING	1993	8,352	557	VARIOUS	557		5,104	38	
39	ELEVATOR	1993	10,788	561	VARIOUS	561		5,155	39	
40	REMODELING	1993	48,830	2,384	VARIOUS	2,384		21,867	40	
41	PARKING LOT IMPROVEMENTS	1994	4,300	430	VARIOUS	430		3,798	41	
42	ELEVATOR	1994	3,368	168	VARIOUS	168		1,431	42	
43	RENOVATIONS	1994	57,905	3,174	VARIOUS	3,174		26,065	43	
44	PARKING LOT IMPROVEMENTS	1995	11,934	1,151	VARIOUS	1,151		8,253	44	
45	REMODELING	1994	55,764	2,839	VARIOUS	2,839		21,789	45	
46	DOORS	1994	4,684	232	VARIOUS	232		2,253	46	
47	REMODELING	1995	2,320	116	VARIOUS	116		841	47	
48	REMODELING	1995	12,720	669	VARIOUS	669		4,742	48	
49	ROOF REPAIRS	1995	20,660	1,065	VARIOUS	1,065		7,549	49	
50	ROOF AIR CONDITIONER	1995	40,354	3,558	VARIOUS	3,558		23,878	50	
51	ROOF AIR CONDITIONER	1995	2,950	295	VARIOUS	295		1,893	51	
52	RENOVATIONS - KITCHEN/DINING	1995	264,018	14,668	VARIOUS	14,668		97,785	52	
53	RENOVATIONS - KITCHEN/DINING	1996	5,613	312	VARIOUS	312		1,949	53	
54	RENOVATIONS - BATHROOM	1996	79,899	3,995	VARIOUS	3,995		24,636	54	
55	FLOORING	1996	15,511	1,551	VARIOUS	1,551		9,436	55	
56	WINDOWS	1996	3,028	151	VARIOUS	151		871	56	
57	ENTRANCE CANOPY	1996	1,580	158	VARIOUS	158		895	57	
58	ELECTRIC DOORS	1996	5,072	437	VARIOUS	437		2,472	58	
59	ROOFING	1996	22,900	2,290	VARIOUS	2,290		12,977	59	
60	REPAIR BOILER ROOM	1996	3,300	330	VARIOUS	330		1,870	60	
61	REFURBISH SIGN	1996	1,200	120	VARIOUS	120		680	61	
62	ENTRANCE CANOPY	1997	3,693	369	VARIOUS	369		2,000	62	
63	NURSE STATIONS	1997	34,011	2,126	VARIOUS	2,126		9,743	63	
64	FENCE	1998	3,885	259	VARIOUS	259		1,101	64	
65	DOORS	1998	945	63	VARIOUS	63		231	65	
66	NURSE STATIONS	1998	10,001	667	VARIOUS	667		2,445	66	
67	CHAIN LINK FENCE	1998	4,544	303	VARIOUS	303		1,136	67	
68	BATHS	1999	623,243	31,162	VARIOUS	31,162		101,277	68	
69	WALL ARCHITECTURAL	1999	1,491	75	VARIOUS	75		230	69	
70	TOTAL (lines 4 thru 69)		\$ 5,497,748	\$ 206,933		\$ 206,933	\$	\$ 2,744,336	70	

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
71	Totals from Page 12A, Carried Forward		\$ 5,497,748	\$ 206,933		\$ 206,933		\$ 2,744,336		1
72	SUBACUTE IMPROVEMENTS	2000	75,624	4,020	VARIOUS	4,020		9,714		2
73	RENOVATIONS- BATHROOMS	2000	36,055	1,898	VARIOUS	1,898		4,586		3
74	HANDRAILS	2000	11,693	780	VARIOUS	780		1,884		4
75	HALL FLOOR	2000	30,472	1,604	VARIOUS	1,604		3,876		5
76	ROOF REPAIRS	2000	7,800	433	VARIOUS	433		831		6
77	AIR CURTAIN	2000	1,110	62	VARIOUS	62		118		7
78	BATH RENOVATION	2000	2,438	128	VARIOUS	128		246		8
79	SECOND FLOOR AIR	2000	4,829	268	VARIOUS	268		425		9
80	FACILITY IMPROVEMENTS	2001	274	55	VARIOUS	55		59		10
81	THERAPY FLOOR	2001	3,700	339	VARIOUS	339		339		11
82	THERAPY CEILING	2001	3,194	586	VARIOUS	586		586		12
83	FIRST FLOOR HANDRAILS	2001	12,480	1,456	VARIOUS	1,456		1,456		13
84	SECOND FLOOR AIR	2002	7,400	247	VARIOUS	247		247		14
85	WALL ARCHITECHURAL	2002	7,032	207	VARIOUS	207		207		15
86	GIFT SHOP EXPANSION	2002	16,274	479	VARIOUS	479		479		16
87	CARPET	2002	3,984	266	VARIOUS	266		266		17
88	SECOND FLOOR AIR	2002	274	5	VARIOUS	5		5		18
89	THERAPY FLOOR	2002	180	5	VARIOUS	5		5		19
90	SECOND FLOOR AIR	2002	1,636	16	VARIOUS	16		16		20
91	VINYL FLOORING	2002	5,979	50	VARIOUS	50		50		21
92	THERAPY CEILING	2002	6,930	116	VARIOUS	116		116		22
93	GIFT SHOP EXPANSION	2002	545	9	VARIOUS	9		9		23
94	SECOND FLOOR AIR	2002	76,900	377	VARIOUS	377		377		24
95	ROUNDING		(3)	(2)		(2)		(2)		25
96	NURSE STATIONS(PER FY99 IPA AUDIT)	1995	69,094	3,839	VARIOUS	3,839		26,230		26
97										27
98										28
99										29
100										30
101										31
102										32
103										33
104	GRAND TOTALS		\$ 5,883,642	\$ 224,176		\$ 224,176		\$ 2,796,461		34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,407,070	\$ 81,878	\$ 81,878	\$	VARIOUS	\$ 1,067,800	71
72	Current Year Purchases	37,911	3,053	3,053		VARIOUS	3,053	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,444,981	\$ 84,931	\$ 84,931	\$		\$ 1,070,853	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORT	1990 FORD PARATRANSIT VA	1990	\$ 26,275	\$	\$	\$	4	\$ 26,275	76
77										77
78										78
79										79
80	TOTALS			\$ 26,275	\$	\$	\$		\$ 26,275	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,629,832	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 309,107	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 309,107	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,893,589	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	NURSE STATIONS-1997& 1998	\$ 49,545	\$ 3,098	\$ 14,180	86
87	BATHS-1999	9,818	492	1,595	87
88	NURSING HOME FINDERS FEE-1984	38,500	1,541	28,362	88
89	PROJECT95-028-00-1997	6,940	435	1,988	89
90	EQUIP-BEDS-1983	1,690		1,690	90
91	TOTALS	\$ 106,493	\$ 5,566	\$ 47,815	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 3,666 Description: COPY MACHINE - \$3,666

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ \_\_\_\_\_

13. /2004 \$ \_\_\_\_\_

14. /2005 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>COMMUNITY COLLEGE      <input type="checkbox"/></p> <p>HOURS PER AIDE      <u>80</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>HOURS PER AIDE      <u>48</u></p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract		Total	
1	Community College Tuition	\$	2,880	\$		2,880	
2	Books and Supplies		400			400	
3	Classroom Wages (a)		8,166			8,166	
4	Clinical Wages (b)		4,849			4,849	
5	In-House Trainer Wages (c)		14,777			14,777	
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests		1,050			1,050	
9	TOTALS	\$	32,122	\$		32,122	
10	SUM OF line 9, col. 1 and 2 (e)	\$	32,122				

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	16
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	16

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Line 10a Col. 3	hrs	\$	6,096	\$ 195,507	\$	6,096	\$ 195,507	1
2	Licensed Speech and Language Development Therapist	Line 10a Col. 3	hrs		1,492	52,314		1,492	52,314	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a Col. 3	hrs		10,586	363,534		10,586	363,534	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 39 Col. 2	# of prescrpts				1,217,195		1,217,195	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12										
13	Other (specify):									13
14	TOTAL			\$	18,174	\$ 611,355	\$ 1,217,195	18,174	\$ 1,828,550	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 39,795	\$	1
2	Cash-Patient Deposits	11,137		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,156,616		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	625,504		5
6	Prepaid Insurance	24,598		6
7	Other Prepaid Expenses	11,311		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(2,789,405)		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (920,444)	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (920,444)	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 411,672	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,136		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	287,025		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 709,833	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 709,833	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,630,277)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (920,444)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,911,821)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,911,821)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>143,228</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>(4)</b>	<b>15</b>
<b>16</b>	Other (describe) <b>Partnership revenue</b>	<b>138,320</b>	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>281,544</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,630,277)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number The Carle Arbours

# 0028522

Report Period Beginning: 07/01/01

Ending:

06/30/02

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1		2	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,243,013	1
2	Discounts and Allowances for all Levels	(3,097,629)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,145,384	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,683,771	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,683,771	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	10,363	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,966	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	25,500	16
17	Sale of Drugs	772,464	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 810,293	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,267	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,267	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See attached schedule	10,636	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 10,636	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,651,351	30

2		3	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,358,573	31
32	Health Care	3,773,019	32
33	General Administration	1,713,614	33
<b>B. Capital Expense</b>			
34	Ownership	754,452	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	771,997	35
36	Provider Participation Fee	136,468	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,508,123	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	143,228	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 143,228	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number The Carle Arbours# 0028522Report Period Beginning: 07/01/01Ending: 06/30/02

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	272	280	\$ 9,806	\$ 35.02	1
2	Assistant Director of Nursing	2,008	2,160	45,758	21.18	2
3	Registered Nurses	14,948	16,553	393,486	23.77	3
4	Licensed Practical Nurses	35,365	38,208	608,190	15.92	4
5	Nurse Aides & Orderlies	82,294	88,987	898,948	10.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,523	4,154	45,033	10.84	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,824	2,160	25,479	11.80	9
10	Activity Assistants	7,581	8,429	77,503	9.19	10
11	Social Service Workers	5,110	6,160	104,717	17.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,880	2,080	40,235	19.34	14
15	Cook Helpers/Assistants	34,589	37,131	357,976	9.64	15
16	Dishwashers					16
17	Maintenance Workers	3,588	3,970	47,220	11.89	17
18	Housekeepers	15,459	16,618	151,744	9.13	18
19	Laundry	7,851	8,545	71,592	8.38	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,920	2,120	42,764	20.17	22
23	Office Manager					23
24	Clerical	9,365	10,518	166,233	15.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,417	6,966	82,280	11.81	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	233,994	255,039	\$ 3,168,964 *	\$ 12.43	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	N/A	9,600	Ln 9 Col. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,600		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	669	\$ 32,211	Ln 10 Col. 3	50
51	Licensed Practical Nurses	2,030	102,086	Ln 10 Col. 3	51
52	Nurse Aides	10,709	250,179	Ln 10 Col. 3	52
53	TOTAL (lines 50 - 52)	13,408	\$ 384,476		53

Facility Name & ID Number The Carle Arbours# 0028522Report Period Beginning: 07/01/01Ending: 06/30/02

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
J. SNIDER	ADMINISTRATOR		\$ 74,000	Workers' Compensation Insurance	\$ 26,481	IDPH License Fee	\$ 5,100	
				Unemployment Compensation Insurance	1,756	Advertising: Employee Recruitment	13,927	
				FICA Taxes	236,416	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	319,542	ADVERTISING	21,595	
				Employee Meals		P/R & ENTERTAINMENT	3,261	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA DUES	9,779	
				LIFE INSURANCE	3,109	SUBSCRIPTIONS	236	
				LONG TERM DISABILITY	8,467	OTHER DUES & FEES	452	
				PENSION	88,154			
				TUITION REIMBURSEMENT	10,375	Less: Public Relations Expense	(3,261)	
				PRE-EMPLOYMENT PHYSICALS	25,541	Non-allowable advertising	(20,912)	
				EMPLOYEE INCENTIVES	5,683	Yellow page advertising ( _____ )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 74,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 725,524	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 30,177	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
HERITAGE ENT - MGMT SERVICE			\$ 279,341	NONE			Out-of-State Travel	\$ _____
FARNSWORTH - CONSULTING FEE			1,201					
							In-State Travel	294
							Seminar Expense	2,148
							Entertainment Expense ( _____ )	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 280,542	TOTAL		\$ _____	TOTAL	\$ 2,442
C. Professional Services								
Vendor/Payee	Type		Amount					
CARLE HOSPITAL	RELATED PARTY		\$ 187,134					
CARLE CLINIC ASSOC.	DATA PROCESSING		19,969					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 207,103					

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union?    No
- (2) Are there any dues to nursing home associations included on the cost report?    Yes  
If YES, give association name and amount.    IHCA - \$9,779
- (3) Did the nursing home make political contributions or payments to a political action organization?    No    If YES, have these costs been properly adjusted out of the cost report?    \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?    No    If YES, what is the capacity?    \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases?    Yes  
What was the average life used for new equipment added during this period?    6.1
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.    \$ 26,364    Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?    Yes    If NO, attach a complete explanation.    \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement?    No  
If YES, give effective date of lease.    \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement?    \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?    YES \_\_\_\_\_ NO x    If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.    \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.    \$ 131,400  
This amount is to be recorded on line 42 of Schedule V.    \_\_\_\_\_
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?    No    If YES, attach an explanation of the allocation.    \_\_\_\_\_
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?    Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?    No    For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.    \_\_\_\_\_
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.    \$ N/A    Has any meal income been offset against related costs?    Yes    Indicate the amount.    \$ 1,966
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel?    No  
If YES, attach a complete explanation.    \_\_\_\_\_  
b. Do you have a separate contract with the Department to provide medical transportation for residents?    No    If YES, please indicate the amount of income earned from such a program during this reporting period.    \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients?    0%  
d. Have vehicle usage logs been maintained?    Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?    Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?    Yes  
g. Does the facility transport residents to and from day training?    No  
Indicate the amount of income earned from providing such transportation during this reporting period.    \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm?    Yes  
Firm Name:    McGladrey & Pullen    The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?    Yes    If no, please explain.    \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?    Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?    N/A  
Attach invoices and a summary of services for all architect and appraisal fees.    \_\_\_\_\_